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"A Doctor's Viewpoint of Whole Food," by Dr. Yellowlees

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A Doctor's Viewpoint of Whole Food

by Dr. Yellowlees

A shorter version of the talk given at the Attingham Conference. Dr. Yellowlees has a practice in Perthshire and has been a member of the Soil Association for fifteen years.

Twenty-seven years ago, when I sat in a university lecture room, the Professor of Therapeutics would begin his course of lectures by saying that the active agents, that is, those medicines which did any good at all in altering the course of the disease, could almost be counted on the fingers of one hand. Quinine did help malaria, soluble arsenical compounds could bring to a halt the advance of syphilis, liver extract could cure pernicious anemia—and a few others. But apart from these he would say, "If all the medicines being prescribed in Britain today were thrown into the sea, only the fish would suffer."

Yet even at that time this emphasis on the lack of effective drugs was getting out of date. For in the adjoining wards of Edinburgh Royal Infirmary we were shown patients admitted to the hospital suffering from pneumonia, who, instead of getting worse and undergoing the harrowing course of this disease, were free from fever in forty-eight hours, sitting up and asking for nourishment.

This was thanks to May and Baker's new sulphonamides—the "M and B's"—the magic tablets which were proving to be effective in a number of hitherto untreatable conditions.

And so the new age of medicine was born, the renaissance in doctoring that began in the mid-1930s. A few years later, during the war, penicillin came on the scene and astonished the world with its efficacy. After the war the biochemical revolution quickened its pace.

New broad-spectrum antibiotics came fast and in profusion. Streptomycin was found to deter the tubercule bacillus, and at last the conquest of tuberculosis seemed in sight. Cortisone, hypotensives, the tranquilizers, the anticoagulants, poured from the busy laboratories like water from a fountain

Into the hands of the medical profession had been put sharp, gleaming swords.

The impotence in the face of disease of the doctors of the pre-sulfonamide era, so eloquently expressed by my professor, was a thing of the past, and it seems that both doctors and patients have become so dazzled by these outstanding successes in the field of disease treatment that *they have been blinded to the simple truth that many of the diseases need never have occurred.*

The validity of this simple truth, as I have called it, had been given to the world in 1936, when the late Sir Robert McCarrison[17] delivered his Cantor Lectures before the Society of Arts. He gave the results of his researches into the relationship between food and health, and made a plea for creating a healthy nation on the basis of food that was fresh and whole.

Maybe it was an ironic twist of fate that the new understanding of the *cause* of disease came about the same time as the renaissance in disease *treatment.*

Prevention and Treatment

So, the medical professions of all advanced countries seem bent on devoting most of their energies to dealing with results, rather than causes.

I think this attitude is well summed up in an opinion expressed in the *B.M.J.* leading article last year.[1]

Professor A.B. MacGregor, in an epidemiological survey of dental caries in Ghana, had reported a generally lower incidence of tooth decay than in this country, except in the case of the wealthier Ghanaians who could afford to buy imported refined flour and sugar. In this group the rate of decay approached that of Britain. As the standard of living in Ghana rises, it was predicted, soon the whole population would be eating not their own indigenous cereals but the imported refined carbohydrates. So dental caries in Ghana would become the scourge which it is in Britain. To meet this situation the article suggested the urgent necessity of a crash program (how planners love crash programs) for the training of African dentists. Or, in other words, arrange for a disease to happen and then call for urgent, expensive measures to treat it!

Somber Statistics

As a nation, although our mortality statistics have shown steady improvement, we do not appear to get any healthier.

In 1956, the report from the Department of Health for Scotland[2] included this statement: "The hospitals are busier than ever, more outpatients and more patients treated in the wards…Morbidity statistics from the Ministry of Pensions and National Insurance show no decline in the incidence of certifiable sickness."

In 1964, the same report stated: "In terms of hospital attendances and demands for hospital treatment it might seem that ill health was increasing. There is no simple satisfactory explanation of the fact that better disease control, the saving of lives and improved environment are still accompanied by heavy sickness incidence."

The average number of weeks of sickness benefit for employed men in Great Britain (excluding civil servants) increased from 2.04 weeks in 1959–60 to 2.20 weeks in 1962–63. The increases occurred in all age groups.[4]

In England and Wales, the annual rate of discharge from hospital beds for acute illnesses has been rising from 61 per 1,000 population in 1953 to 70 per 1,000 in 1963.[5]

Some 90,000 school children in Britain are now leaving school with a full set of dentures.[6]

These are somber statistics. Seventeen years' experience as a GP in a Highland community has not shaken my conviction that improvement will never come about while our people continue their present disastrous dietary habits. Year by year incidents hammer home this truth.

A few years ago, I attended a young mother in her first confinement. She was just five feet tall and her father was a farm worker. She had a long, difficult labor ending in operative delivery and a stillborn baby. *Studies in Aberdeen* by Professor Sir Dugald Baird[7] have shown that in Social Class I (that is, the professional classes), only 6 percent of mothers are under 5 feet, 1 inch in height, whereas in Social Class V the percentage of small women is 30. The stillbirth rates in Class V are 50 percent more than in the professional classes, and the neonatal death rate, that is the death rate of babies in the first month of life, is no less than 100 percent more.

Here is a classic example of the supreme importance of dietary factors in disease prevention. The small stature of the poorer mothers is due to their inferior diet, their pelvic bones tend to be too small to permit the safe passage of the baby. They are more prone to anemia, toxemia, and abnormality of all kinds.

I was discussing these things recently in a large hospital with an obstetrician and suggesting that the whole aspect of maternity hospital work would change if only we could upgrade the diet of normal women from Social Class V to that of Social Class I. "Yes," he replied, "and *we* would be out of a job."

Evidence that Whole Food Improves Health

The steepest fall in stillbirth and neonatal death rates occurred during the war. A dramatic improvement that is generally attributed to the wartime food policy—a time when sugar was rationed, the extraction rate of flour was raised, and the consumption of fresh milk greatly increased. It cannot have been due to improved maternity services, for there was a war time shortage of doctors and nurses.

But the experience in Holland[7] is even more relevant for those interested in whole food, because there—although during the German occupation food became scarce— the stillbirth rate fell from 25 per 1,000 births before the war to 19 in 1944. Most of this improvement was due to decrease in toxemia of pregnancy, which is the commonest cause of stillbirth, and the Dutch authorities consider that the improvement was due to the abolition of peacetime overeating. There is other evidence that a high intake of refined foods such as sugar and refined flour is the main cause of pregnancy toxemia.

Dr. E.H. Hipsley reported some time ago in the *B.M.J.* the results of surveys of pregnancy toxemia in Fiji.[8] Among the Fijian women studied, the incidence of toxemia in the years of study was zero, whereas in the Indian community living in Fiji it was relatively high. The Fijian diet consists of fresh vegetables, fruits, and small quantities of meat, fish, and crabs, the bulk of the Indian diet is refined flour and rice.

This experience agrees exactly with a delightful essay written by Dr. Mary Jackson[9] on her work in Northern Alberta among the Metis Indians. She went there in 1930 and for the first twelve years never saw a case of pregnancy toxemia.

But during the war the Mackenzie Highway to the northern oil fields and uranium mines was driven through this this territory. The Indians were given highly paid jobs and access to imported food.

Instead of fresh meat, fresh fruit, beans, eggs, and the flesh of fish or birds, they began eating white bread, sugary processed breakfast foods, puddings, sweet biscuits, candy, and chocolate. For the first time cases of pregnancy toxemia began to appear. To quote Dr. Jackson, "So a rising standard of living, and a considerable measure of social security have been accompanied by an increase in the incidence of dental caries and a falling standard of health in pregnant and old people."

How often, as the cause of a disease is finally explained after patient, complex research, the case for dietary reform is strengthened. Here again I quote from personal experience.

In 1959, I attended a tinker woman in her second pregnancy. The tinkers have a social class zero of their own. Their men folk are seldom in constant employment and and so depend on public assistance; they live a hand-to-mouth existence on the cheapest food. Thorough antenatal care in this case was impossible as the woman wouldn't come to the surgery and was constantly shifting her tent. After having her baby in our hospital, she developed a swinging fever and severe gastrointestinal symptoms. I thought she had gastroenteritis or dysentery and sent her to the isolation hospital. There examination of her blood showed that she was suffering from macrocytic or megaloblastic anemia of pregnancy. In 1961, another tinker, who early in her pregnancy was found to be gravely anemic, proved to be suffering from the same complaint. Both these women improved rapidly on being given tablets of folic acid. This is a vitamin which, as its name suggests, is found in green leaves of vegetables and, to a lesser extent, in wheaten flour; it is easily destroyed by cooking.

Attention to its action was first published by Dr. Lucy Wills in 1938[10] when she was studying tis megaloblastic anemia in Bombay, among people whose diet consisted mainly of white bread and polished rice. The diet of my tinker patients is probably not much better. Folic acid is essential for the normal production in bone marrow, of the blood's red cells. Without it cell production becomes abnormal and the circulating red cells progressively fewer.

But more recently it has been shown that folic acid deficiency is also associated with some cases of premature separation of the placenta and deformities of the fetus.[11] The former carries high mortality for the baby and grave dangers for the mother.

This vitamin is related to nucleic acid of cell nuclei and is essential for growing tissue, hence the extra need for it and its tremendous importance throughout pregnancy. Studies[12] have shown that deficiency precedes manifest anemia. A recent survey by bone marrow puncture of a random group of pregnant women showed that no less than 25 percent of subjects showed signs of megaloblastic or abnormal cell development. Deficiency of this vitamin in pregnancy is thus fairly widespread, especially among Social Class V.

So, advice to pregnant women to eat whole wheat bread and one raw salad dish becomes not the ravings of a crank, but sound dietary advice based on most recent research. The enterprising drug firms have been quick to develop a pill containing both folic acid and iron, and these are now being routinely prescribed in many antenatal

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clinics. But I have read of no authorities questioning the habit of putting in a pill essential food factors that should come from our plates.

Coronary Artery Disease

I wish to turn now to one of the most terrible epidemics of modern times, coronary artery disease.*

One fact is undisputed: primitive races, having as yet no contact with "civilized" foods, show an almost complete absence of this heart disease below sixty years of age, but when these same people have access to "civilized" food they start getting the disease.[13] An interesting example of this was recently published in the *Lancet*,[14] giving information about the changed dietary habits in Israel of settlers from the Yemen. Newcomers from the Yemen had been shown to suffer much less from coronary heart disease, high blood pressure and diabetes than did their fellow Yemenites who had been settled in Israel from more than twenty-five years.

Doctors Cohen, Baily, and Poznanski, who did this work, suggested that the chief cause for this deteriorating health might be the increased consumption in Israel of sugar. In the Yemen no refined sugar was taken by the families studied, whereas when they settled in Israel it formed about 20 percent of their carbohydrate. Otherwise their diets were broadly similar.

There is no general agreement among medical authorities about the cause of the tremendous increase in the last three decades of disability and death due to this disease.

My own feeling is that fats do not play such an important part and that, when the final truth is exposed, this disease will be yet another example of—to quote Cleave— "saccharin disease,"[15]—is a condition due to diets over-heavy with refined carbohydrate.

If dietary factors cause degeneration of arterial walls, it might be expected that other tissues in the same patient would also be affected by degenerative processes.

Diet, Stress and Heredity

Occasionally, studies of individual cases for which the GP is so well placed may be as revealing as the wider surveys of the epidemiologist.

I followed the cases of two men with serious degeneration of the intervertebral discs of their spines and both later developed fatal coronary artery blockage. I believe that the causes of these two quite separate conditions is the same dietary in adequacy. Degeneration of intervertebral discs seems to be another condition on the increase, and it is my opinion that the main cause is inadequate or unbalanced intake of minerals and possibly lack of protein or vitamin factors.

Another thing I have noticed is the frequency with which, on examining many of the people who succumb to coronary thrombosis while on holiday in our practice area, the tell-tale scar of a gastrectomy—that is the operation to "cure" duodenal ulcer—is found in the same patients. This is an impression, with no figures to back it up, but Fry,[16] in his practice near London, has given statistical evidence to suggest that there is an association between peptic ulcer and coronary thrombosis.

"But wait," the protagonists of psychosomatic medicine will say at this point, "the association, if it exists, between these two diseases is because both were caused by the same emotional stress."

My reply would be that the body and mind were built to withstand both physical and mental stress. I sometimes wonder if some people in this Britain of 1965 couldn't do with a bit more stress! I think of the parable of the two houses, one built on sand, the other on rock. When the storms of stress blow hard, the inadequately fed organism, nourished on the deprived foodstuffs of today, will wear out or collapse. An adequately nourished organism will stand.

Probably hereditary factors determine which system or organ will breakdown first when the individual is exposed to adverse dietary factors.

Two bachelor brothers lived on a hill farm. They were not over-intelligent, and the squalor of their kitchen was terrible to see. Their feeding arrangements consisted in getting from the weekly van what could satisfy hunger with the minimum of trouble, and white bread with jam, tea, tinned milk, and tinned meat seemed to be the main items on the menu. Two years ago, one brother developed a painful leg. He was found to have profound anemia and massive hemorrhages typical of scurvy. But the other brother was unaffected, possibly his metabolism was better adapted to utilizing the slender supplies of available vitamin C.

These two brothers might be termed modern-day primitives, their small farm from which they seldom strayed is surrounded by luxuriant growth of green things, mostly nettles and other weeds. What a sad reflection that they had lost even the instinctive sense to cultivate a few potatoes or turnips.

Not far away by the road, an old lady almost ninety sits by her fire and speaks, as is usual in the aged, of the days gone by, deplores—again as old people do—present-day customs. We can ignore her opinions, if we like, as being the rambling of senescence, but her account of the nutrition of her childhood is interesting. "We had plenty of everything on our farm," she has said to me. "We had cows and sheep and hens. We made lovely cheeses and lots of fresh butter."

The Remedy Is Too Simple

The other day I came across a remarkable echo of "The weakness of the remedy lies in its simplicity." James Lind, the Portsmouth Naval Surgeon who had suggested that scurvy among sailors could be prevented by a ration of lemon juice, wrote, "Some persons cannot be brought to believe that a disease so fatal can be prevented by such easy means. They would have more faith in an elaborate composition dignified with the title of an anti-scorbatic golden elixir or the like."

Although we have seen in recent decades a tremendous expansion of human knowledge of material things, I doubt if we have matched our increase in knowledge with a deepening of our wisdom.

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